ARIZONA DEPARTMENT OF HEALTH SERVICES
Office for Children with Special Health Care Needs

TO:	NAME *(Last, First, M.I.)*
	BIRTHDATE
FROM:	ADDRESS *(Street/PO Box)*
	CITY/STATE/ZIP CODE

AUTHORIZATION FOR RELEASE OF INFORMATION

INFORMATION REQUESTED

[	Medical Records	[ ]	Treatment Progress Notes
[	Psycho/Educational Evaluations	[ ]	Behavioral Health Records
[	Psychological Reports	[ ]	Individualized Service Plan
[	Therapy Reports	[ ]	Individual Education Plan
[	Service Reports	[ ]	Service Plans
[	Developmental Evaluations	[ ]	Social History
[	Vocational Evaluations	[ ]	Other *(Specify)* _____

The information sought is the minimum amount of information OCSHCN needs for the purpose stated below.

Comments: _____

AUTHORIZATION

I authorize the above named company, school, agency, health care provider, or individual to disclose to the Arizona Department of Health Services, Office for Children with Special Health Care needs (ADHS/OCSHCN) the above-indicated health, medical information, and/or other records requested. The purpose of this release is to assist in providing services. This authorization shall expire one year from the date below.

I understand that I can revoke this authorization at any time by written notice to the provider of records, except to the extent that the disclosure authorized has been acted upon prior to receipt of any written revocation.

I understand that I do not have to sign this authorization. If I do not sign it, I understand that ADHS/OCSHCN may not be able to assist in providing services. I understand that a health plan may not condition treatment, payment, or enrollment in a health plan on my signing this authorization.

I understand that once the records and information authorized herein are disclosed to entities or persons outside of ADHS/OCSHCN, they could be redisclosed by the recipient(s) and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. However, ADHS/OCSHCN service providers are bound by contract and law to maintain the confidentiality of health and other information received, especially that relating to HIV infection, AIDS or AIDS-related conditions, and psychological or psychiatric conditions.

I understand that the information is deemed to be confidential and privileged information pursuant to Arizona Revised Statutes ARS 36-441, A.R.S. 36-445, A.R.S. 36-2403, A.R.S. 36-2017 and any other applicable Arizona law.

I understand that I have a right to have a copy of this form.

_____	_____	_____
Representativeôs Name *(Print Name)*	Representativeôs Signature	Date

My authority as a representative to make decisions for this person is:

☐ Self ☐ Parent of a minor ☐ Guardian ☐ Court appointed Conservator ☐ Health Care POA

This authorization was revoked/withdrawn on: _____ _____

Date Signature of Staff

A FACSIMILE OR PHOTOCOPY OF THIS AUTHORIZATION IS CONSIDERED TO BE AS AUTHENTIC AS THE ORIGINAL